NEW YORK CITY MEDICAL CARE— SOME PROBLEMS AND PROSPECTS

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WHAT I propose to do is to talk about the kind of medical care people ought to get, and to offer some suggestions about how to provide it, chiefly concerned with planning. I recognize that there are many efforts in this connection, some quite good: George Reader's comprehensive program at Cornell; what Ray Trussell* has done in many areas of planning for medical care; the fine program which Al Yerby** is developing for Department of Welfare clients. There are many others as well.

First, what is adequate medical care?

To start at the beginning, there should be the broadest range of preventive services geared to the special needs of various groups such as pregnant women, infants, children, adults and the aging. The highest goal of medical care is to prevent disease, and medical science should be utilized as fully as possible to this end. Since disease is ever present, appropriate health personnel and facilities for diagnosis and active treatment are required, and since failures to cure unavoidably occur, there must be provisions for care of the long-term sick.

There are two broad and basic requirements of an adequate medical care program for the community. The first is that medical care must be so organized and financed that all social and economic strata of the population will have easy access to the services they require. Second, there must be not only sufficient medical care personnel and services and facilities, but there must be also the assurance of good quality.

Good quality medical care has two facets: 1) patient satisfaction—no medical care can be considered of good quality if it does not reasonably meet the expectations of the people who use it; 2) the competence of the health personnel, particularly the doctor, and the assur-

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ance that the appropriate diagnostic tools and procedures are applied and the proper therapeutic regime undertaken, and that all this is done to the limit of our skill and professional capacity.

There are of course other factors in good quality care, but I think you will agree that if these elements were uniformly present in New York we could afford to be proud. For one group here and for another there, we have bits and pieces of this program which are very good. On the other hand, we have deficits in medical care which are and should be the cause for much concern. One need go no further than yesterday's newspaper to get a notion of how far short of good quality the medical care in this community can be.

In the study done by Columbia University, sampling the medical care received by some teamsters and their families, a significant portion of it was found to be of poor quality. We believe pretty generally in this society that "you get what you pay for." This certainly doesn't apply to medical care. There is no evidence that poor quality care costs less in dollars than good care. I think we must also say that the organization and financing of medical care in New York has not, in general, been so arranged that patients have easy access to medical care services of good quality. Some of the problems in financing and organization have been dealt with admirably by the Health Insurance Plan but there are still, even in HIP, very important unresolved problems of uniform patient satisfaction and quality.

Some of our hospitals are magnificent, well equipped, well staffed, high quality institutions where you can feel secure about your care. But we still have too many hospitals which haven't even met the minimal standards of the Joint Commission on Accreditation. I must note that it is possible for hospitals to meet, with ingenuity which might be better used, the standards for accreditation and still be worse than mediocre.

As we meet here this morning, there are surgeons operating in New York City hospitals whose training and experience does not warrant the procedures they are undertaking. The other day I met two gynecologists—one a leading American gynecologist, the other Greece's outstanding physician. They told me that cancer of the uterus in competent hands would yield as high as 80 per cent cure, whereas in less skilled hands the rate may be 50 per cent or less. While we don't have all the health personnel we need, or possibly all the money to create a high quality medical care program for all, we certainly are not mak-

ing adequate use of what we do have. I believe that we have sufficient well-trained specialists in obstetrics and gynecology to make it unnecessary for any woman in New York City to have major operative gynecology performed by anyone less qualified. The fragmentation we have in medical care is often due more to poor organization than to inadequate manpower or money.

Our problems in New York City are probably not qualitatively different from other places, but quantitatively they certainly are, for several reasons. One is a willingness and ability to do things. No community in America has so many diverse or worthwhile programs for the care of the sick. It is true that our problems are the most difficult because of the large number of people in the city and the extraordinary and rich diversity of cultural groups which make up our population. Nevertheless, the concern, care and compassion expressed by New Yorkers, both public and private, is unequalled. It is a base upon which to build better medical care.

Our difficulty, however, stems, in part, from our virtue. No community jumps more quickly to respond to discovered or highlighted needs. Programs are created and designed under the influence of a bewildering variety of interests and auspices. We have, as a result, a host of programs of varying quality, of varying support, sometimes with quite unclear objectives. Even worse, we have some programs no longer of value to the community, which soak up the community's money and professional resources, but which tenaciously survive. In many instances, programs operate side by side with virtually the same goals and responsibilities, yet with duplicating facilities and inefficient use of our health personnel. Overlap and fragmentation occur among governmental as well as private agencies.

This melange of medical care activities scatters patient care and can convert the patient into a rubber ball bouncing hither and yon. Leona Baumgartner told the story of the man who was on relief rolls because he had six children to take to six different clinics in six different hospitals. He spent so much time doing this that he didn't have time to work. I have heard that, subsequently, this family was taken over by the Cornell Comprehensive Care Program, and when medical care for this family was integrated and coordinated the father went off relief and back to work. Not only is this situation bad for patients, it is very costly for the community. With hospital costs soaring up to

$50 per day per patient, and all other medical care programs following suit, we cannot afford to pour dollars down the drain nor to squander scarce professional personnel.

What is obviously needed is planning, planning on a scale which we have never done before. We must recognize that not all of those talking about planning really intend to do it. When we hospital people talk about planning, we really mean planning for the other fellow's hospital, not our own. There are as many vested interests as there are programs, and the difficulty is that these vested interests are devoted to noble and virtuous undertakings. It is hard to convince people that their agency, devoted to a noble purpose, to which they have given their money and their energies in support, should merge or change or disappear.

That is why I believe planning must be linked to one of two motivating factors—money or legislation. Money is a powerful and appropriate weapon to be used in the cause of planning. For years Blue Cross paid bills in all sorts of hospitals on the basis of formulas which in no wise took quality into account. There were instances of unaccredited hospitals receiving higher per diem rates than outstanding teaching institutions. Today, Blue Cross, under outstanding new leadership, is beginning to move its enormous fiscal responsibility in the direction of improving the quality of hospital care. A cut-off date has been set, after which Blue Cross will not pay unaccredited hospitals. Already this has stirred quite a few institutions to undertake quality improvements they never thought about before. Home care is a fine device for patient and community. By sweetening the pie, Blue Cross has brought more hospitals into giving home care in the last two years than any of the rest of us could accomplish by fifteen years of inspired oratory.

Dr. Trussell, as a result of his study of Blue Cross plans, has not only encouraged the development of formulas for hospital payment that in some ways relate to quality, but has recommended legislation to set up regional and state-wide planning councils. The Hospital Review and Planning Council of Southern New York is now organizing for the task.

We need a decision as to the unit of New York City, geographic or demographic, that should be the focus for planning. I am convinced that planning probably needs to be done within neighborhoods with certain special medical care activities planned on a borough-wide and

even a city-wide basis. We need to make an estimate of the needs and then to plan the resources–personnel, hospitals, ambulatory services, health centers–required to meet them. We should draw up ideal plans even though we know that present practices, existing institutions, and programs are going to be with us for a long time. If we could at least be confident that from now on new activities, programs and facilities would be in keeping with a sound master plan, then we could look forward to great changes in ten, fifteen or twenty years.

I would like to put forth briefly a skeleton plan. Hospitals, which already are the core of medical care in our society, will tend to be even more so in the forseeable future. The complexity of medicine–the constantly new and most costly tools necessary for diagnosis and treatment, the increasing dependence of physicians upon such resources, the development of chronic disease as a major medical problem of our society with the need for a whole range of services outside the hospital, but needing to be related to it–makes it certain that in the days ahead nursing homes, public health centers, custodial institutions, group practice units, ambulatory service facilities and doctors and their offices will be clustered in and around the hospital.

We must also make some philosophical decisions about the future direction of medical practice. It seems to me that because of increased specialization and the need for teamwork, prepaid group practice will be the optimal method. We have reason to believe that such practice, with heavy emphasis on ambulatory diagnosis and treatment, is one of the most effective means of containing hospital utilization. Therefore, planning should allow for its development.

At the same time, there will be great changes in hospitals. There will be two main categories: the community hospital and the medical-center, teaching and research hospital, linked closely with the medical school. Complex undertakings like neurosurgery will be done only in the great centers. There will be a free flow of patients and personnel both ways between center and community hospital.

I have come to the conclusion, as many of my more knowledgeable colleagues have much earlier, that the way we are going to make the changes necessary in the organization, delivery, payment and improvement of medical care is not primarily by the direct action of the professional groups involved–that is, the doctors, public health people, hospital administrative groups, nursing profession–but rather by the

action of those groups who have the power, both fiscal and political, to make their wishes effective. These, of course, are the consumer groups who utilize medical care and who have the primary stake in readily available, good quality medical care. Our role as professionals is to attach ourselves to such consumer groups, to supply to them the technical expertness and accumulated practical skill they must have in order to chart clear courses of action leading to changes in our medical care structure.

I would like to touch upon one further major point. The key to the entire problem of quality medical care given with high professional competence, humanity, understanding and concern is, of course, the physician. This does not denigrate the vital role of the nurses, social workers, and other health personnel. It is just a recognition of the fact that "as the doctor goes, so goes medical care."

Since it is clear that the doctor is the key to medical care and planning, what is the medical school doing about understanding the doctor's role and educating him for it? With a few notable exceptions, the answer is, not much. Medical schools, short of funds and faculty, burdened with research and education, often do not feel they can or need to instruct themselves in community medical care matters or program or planning. This is wrong on two counts. First of all, when a medical school does take an interest or responsibility, the quality of professional care immediately soars. Even more important, only by involving itself in community medicine can the faculty become aware of and be sensitive to the community needs which the graduating doctor must serve. No one would overlook the research which has advanced medicine so much, but the need for research does not reduce the need for the community to have doctors in ample supply and appropriately prepared for their tasks.

I might also point out that it is not enough for one of the peripheral people in the school to be interested in community medicine. It is the professor of medicine and the professor of surgery who represent the model for the student. I hope that in our planning process in New York every opportunity will be given to our great medical schools to help lead the way.